

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

26963

State File No.

FILED SEP 17 1941 791  
Registration District No.

Primary Registration District No. 1003

Registrar's No. 6755

## 1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Christian Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

## 3. (a) PRINT

FULL NAME Martha Washington Brown

## 3. (b) If veteran,

name war No.

## 3. (c) Social Security

No. None

## 4. Sex

Female

## 5. Color or

race White

## 6. (a) Single, widowed, married,

2 divorced Widowed

## 6. (b) Name of husband or wife

Frank

## 6. (c) Age of husband or wife if

alive \_\_\_\_\_ years

## 7. Birth date of deceased

July  
(Month)4  
(Day)1872  
(Year)

## 8. AGE:

Years

Months

Days

If less than one day

69113

\_\_\_\_\_.hr. \_\_\_\_\_.min.

## 9. Birthplace

Lincoln Co.  
(City, town, or county)Missouri  
(State or foreign country)

## 10. Usual occupation

Housewife

## 11. Industry or business

MOTHER FATHER

12. Name James Thurman13. Birthplace Missouri  
(City, town, or county)14. Maiden name Susan Jones  
(State or foreign country)15. Birthplace Missouri  
(City, town, or county)16. (a) Informant Mrs. L. Drummond(b) Address 6526 Joseph Ave.17. (a) Removal

(Burial, cremation, or removal)

(b) Date thereof

8/19/41  
(Month) (Day) (Year)(c) Place: burial or cremation Jonesburg, Mo.18. (a) Signature of funeral director Albert H. Hoppe(b) Address 4700 Washington Ave.19. (a) AUG 19 1941

(Date received local registrar)

(b)

(Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town Wellston  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1520 Ferguson  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 17  
year 1941 hour 6:00 minute A M.

21. I hereby certify that I attended the deceased from  
July 10, 1941, to Aug 17, 1941;  
that I last saw him alive on Aug 16 - P.M., 1941;  
and that death occurred on the date and hour stated above.

## Immediate cause of death

Cardiac failure  
No definite heart disease

Due to Cachexia

Due to cerebral hemorrhage  
hemiplegia - left side

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings:

Of operations

Of autopsy

## PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged statistically.

## 22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature W. J. Wilson M.D. (M. D. or other) DAddress 6149 Natural Bridge Date signed 8/18/41

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. 4202

P. O. Address \_\_\_\_\_

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**